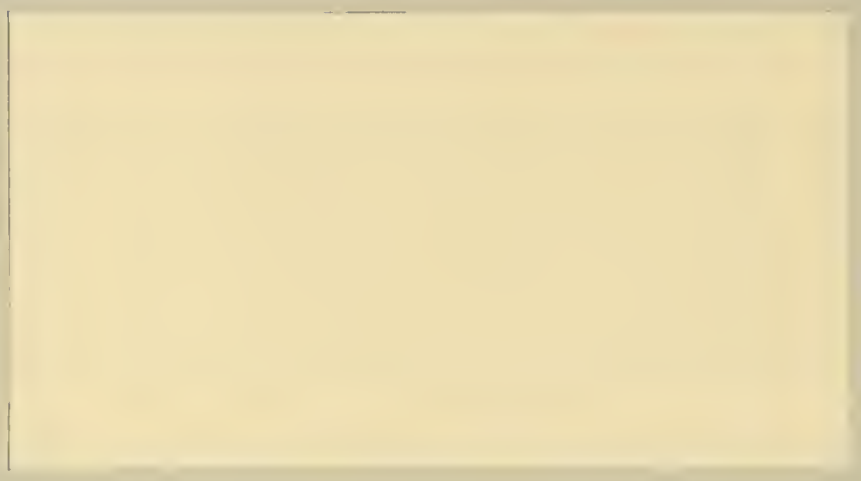
STATE OF MONTANA

ANALYSIS AND EVALUATION OF CLAIMS PROCESSING AND PAYMENT PROCEDURES

September 1994

OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MONTANA
STATE CAPITOL • HELENA



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September 1994

THE SEGAL COMPANY

STATE OF MONTANA

Office of the Legislative Auditor

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August 29, 1994

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the audit of the Employee Benefit Plan for the period March 1, 1992 through February 28, 1994.

The audit was conducted by The Segal Co. under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agency's written response to the report recommendations is included in the back of the audit report.

Respectfully submitted,

Scott A. Seacat
Legislative Auditor

94C-07

THE SEGAL COMPANY

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John J. Coyle
Vice President

September 7, 1994

State of Montana
Office of the Legislative Auditor
Helena, Montana

Re: State of Montana Employee Benefit Plan

Ladies and Gentlemen:

It is a pleasure to submit this report, which sets forth the results of our evaluation of the claims processing and payment procedures utilized by Blue Cross and Blue Shield of Montana (BCBS) for the State of Montana Employee Benefit Plan.

Our onsite review was conducted in June, 1994. The preliminary report was presented to BCBS and the State's Department of Administration for their review. Their responses are provided in Sections VII and VIII, respectively. As appropriate, issues of clarification addressed in these responses have been incorporated in this final report.

This report would be incomplete without recognition of the cooperation and assistance of BCBS staff and State personnel extended to us during the onsite audits and review process.

On behalf of The Segal Company, we appreciate the opportunity to assist the State of Montana in this project. We look forward to discussing this report with you and answering any questions you may have.

Sincerely,

John J. Coyle

JJC:MLW:jn

jn/c/docs/montana

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SECTION I
INTRODUCTION

The State of Montana provides self-insured medical benefits for active employees and retired employees electing to continue coverage under the State Employee Benefit Plan, as well as for their dependents. Self-insured dental benefits are provided for active employees and retirees to age 65. The State has contracted with Blue Cross Blue Shield of Montana (BCBS) to provide claims administration services only.

Purpose of the Audit

Montana State Law (Section 2-18-816) requires that the State employee group benefit plan be audited every two years. The audit must cover the two-year period since the last audit and be conducted by or at the direction of the Legislative Auditor.

The prior report prepared by Wolcott & Associates, Inc. and delivered November, 1992 reviewed the two-year period March 1, 1990 through February 29, 1992. Our review encompasses the subsequent audit period of March 1, 1992 through February 28, 1994.

BCBS implemented a new claims processing system for the State's plan on October 1, 1992. The Legislative Auditor believed that this resulted in major disruption of claims flow through December 31, 1992 and directed the audit to review three separate time periods: March 1, 1992 through September 30, 1992; October 1, 1992 through December 31, 1992; and January 1, 1993 through February 28, 1994.

Dates and Locations

The Office of the Legislative Auditor advised The Segal Company of their award for this audit endeavor on March 10, 1994. Preliminary phases of our review with BCBS included the request of claims tape data and responses to an administrative questionnaire. The selection of claims to be sampled was stratified by dollar amount for each of the three audit periods. Mr. David A. Bauer, Internal Auditor, was our primary contact with BCBS and assisted in coordinating all phases of this project.

Our review began with a visit to the State's Department of Administration (Room 130, Mitchell Building) on June 7, 1994. Analysis of BCBS's Helena claims office (404 Fuller Avenue) was initiated on June 8, 1994. Ms. Peg Hasner, BCBS Internal Auditor, assisted in the daily review of claim audit worksheets.

The audit was completed and an exit interview held on June 15, 1994 with BCBS representatives, Ms. Joyce Brown (Chief, Employee Benefits Bureau) and Ms. Maureen Leo (Financial-Compliance Auditor).

Segal Audit Personnel

The Department of Administration review was conducted by Ms. Kimberly Keenan, (onsite supervising auditor) with assistance from Ms. MaryAnne Watson (project leader). Ms. Lynn Patton and Ms. Sondra Racki, senior claims auditors, joined the team on June 8, 1994 for our review of BCBS.

Segal's audit division is managed by John J. Coyle, Vice President and Benefits Consultant. Ms. Watson, National Practice Leader of Claims Auditing Services, coordinated this review with the State and BCBS. Independent review of the auditors' report was performed by Ms. Virginia Rollo, Benefit Consultant for Claims Auditing Services.

The stratified selection process was performed by actuarial staff at the direction of Stephen A. Meskin PH.D, Senior Health Actuary. Statistical analysis was performed by Dr. Meskin.

SECTION II

BCBS CLAIMS ADMINISTRATION PROCEDURES REVIEW

Self-funded medical and dental benefits for eligible participants of the State of Montana Employee Benefit Plan are administered by Blue Cross Blue Shield of Montana (BCBS).

As part of the onsite claims audit, we reviewed the day-to-day claims processing procedures utilized by BCBS with emphasis placed on the State Plan. This general administration review enables us to determine if proper claim control measures are in place for efficient adjudication of Plan benefits. During the course of this review we conducted personal interviews, reviewed written policy procedures and documentation, and received a tour of BCBS's Helena operations.

The administrative review at BCBS's Helena claims office focused on the following areas:

List of Administrative Procedures Reviewed

- Administrative Staff
  - division of responsibilities established for effective administration of the Plan
  - experience of staff assigned to the Plan
  - training of new examiners and continued educational programs
  - quality assurance programs to monitor compliance with established procedures
- Mail Handling System
  - receipt, opening, sorting, front end entry, and distribution of mail
  - storage and retrieval of claims documentation
- Enrollment and Eligibility Updates to the Claims Adjudication System
- Communications to Participants and Providers
  - consistency between the administration of benefits and explanation provided to participants through the summary plan descriptions, notices, etc.
  - customer service accessibility
  - experience of customer service personnel
  - forms used in the submission of claim charges
  - requests for additional information and follow-up procedures
  - clarity of explanation of benefits statements
  - denial and appeal procedures

- Processing Guidelines
  - procedures and guidelines used in the adjudication of claims
  - reference materials available to examiners
  - interface of the claims adjudication system with precertification, utilization review, and large case management determinations
  - hospital audit guidelines and procedures
- Detection and Investigation of:
  - pre-existing conditions
  - on-the-job injuries/illnesses (worker's compensation)
  - third party liability (subrogation)
  - coordination of benefits
  - full-time student and handicapped child provisions
  - fraudulent claims, unbundled claims and inflated codes
- Maintenance of Fee Schedules and Provider Files
  - additions and deletions to provider records
  - determination and updates to usual, customary and reasonable (UCR) fee schedules for member, nonmember and preferred provider networks
- Claims Processing System
  - personnel authorized to access the claims system and the extent of their authority
  - duplicate payment edits
  - system updates for changes in plan design
  - reporting information provided to the Department of Administration
- Financial Procedures
  - draft issuance, maintenance of check registers and reconciliation with monthly bank statements
  - security of blank draft stock including procedures for storage, signature and authorized access
  - handling of voided, duplicate, stale dated and stop-payment drafts
  - recovery of overpaid claims and credit back to the Plan's experience

Administrative Staff

Specialized departments have been established to assist in the effective flow of administrative duties (e.g. mail, customer service, front-end data entry, error resolution technicians, member accounting, utilization review, internal audit, and provider maintenance).

Training techniques include such avenues as classroom education, one-on-one evaluation, 'as needed' for major enhancements or procedural changes, and memo updates. Error resolution manuals provide a detailed explanation of each system edit and provides steps for claims resolution.

Internal audits are performed by an independent BCBS unit on a post-pay basis. The percentage of claims to be randomly sampled is based on the examiner's production and performance of claims processed from the prior quarter. Internal parameters and quality assurance goals are set by NMIS and monitored by the internal audit department. BCBS has established accuracy goals of 99% financial and 97% overall processing.

Mail Handling

Mail is received in both the Helena and Great Falls BCBS mail rooms. All mail is opened and handled on a daily basis. Special addressee mail is delivered direct to the appropriate party. Helena receives an estimated 20,000 pieces of mail monthly, of which approximately 70% are actual claims.

As the mail is opened in Helena, an initial sort for special attention mail and prescription drug claims is performed. Claim documents for all client groups are batched and sent by daily courier to Great Falls for subsequent handling.

The Great Falls mail room performs an additional sort by claim type (e.g. hospital, dental, medical). Claims are then delivered to Batch Control which examines claims for completeness, batches each claim type into groups of 100 or less, and prepares the claims for microfilming. Batches are then manually logged for claims volume by claims type and delivered to Micrographics for filming. Upon completion of filming, Batch Control delivers claims to the Claims Entry and Exam Department where they are entered into the 'front-end' claims system.

Electronic claim submissions account for a large amount of the overall claims receipts. BCBS's estimates for in-state providers are 51.8% physicians, 39.1% hospitals, and 77.1% for Blue Shield 65 plans. While this breakdown is based on total submissions received by BCBS, it should closely resemble the percentage of electronic submission for the State's Plan. We expect the frequency of electronic claims transfers to increase significantly as providers respond to Medicare's push to become 'paperless' in the near future.

Enrollment and Eligibility Updates To The Claims Adjudication System

The State makes appropriate employee payroll deductions for coverage under this Plan and is responsible for collection of all self-payment and Cobra premiums. Notification of all eligible plan participants and respective coverage changes is made to BCBS via tape by the appropriate times indicated in the claims administration services agreement.

BCBS updates their system within three days of receipt of the State's eligibility tape. Updates for active participants and self-payments are submitted mid-month; Cobra updates are provided by month's end. All claims for the current month are suspended by BCBS until current eligibility information is received. Once current eligibility information is received, these suspended claims are released for claims adjudication.

Deficiencies were identified in the eligibility procedures used by the State and BCBS. Included in Section III of this report is a more detailed review of the procedures in use at the time of our June, 1994 visit, along with our concerns and recommendations.

Communications To Providers and Participants

Standard form letters requesting additional information needed to properly process a claim are sent by the examiner. Only one request is sent prior to denial of the claim for lack of information. There is a variance in the number of follow-up days prior to denial based upon the type of information being requested.

Explanation of Benefits (EOB) messages are generated by the system. The claims draft is part of the EOB form. EOB copies are distributed, as applicable to a specific claim (i.e., the subscriber for each claim processed, assigned allied providers, and assigned out-of-state providers with payment exceeding $300.00).

Draft distribution is performed weekly based on the provider type: Monday, provider batch drafts for participating institutions (hospitals) and participating providers; Tuesday and Thursday, allied providers with assignment, employee drafts, and employee EOB copies for participating providers; and Friday, all participating physician drafts. Participating providers continue to receive a payment register with their bulk payments. Claim payment is mailed weekly as opposed to the previously established monthly system.

Customer Service responsibilities have been assigned to a unit dedicated solely to the State of Montana. A team of six representatives receives 500-600 telephone inquiries each week. This team is responsible for responding to verbal and written employee and provider requests, and assists in the coordination of information required by multiple departments. BCBS indicates that 91% of all telephone inquiries are handled without a referral or return call being necessary. Documented customer service logs are directly input to the file of the employee involved in the phone inquiry. A quality assurance program was implemented February 1, 1994 to record all phone calls and monitor response time on a daily and weekly basis.

Appeals are handled in accordance with BCBS internal appeal process which begins with the inquiry of the provider or subscriber through the customer service department. Upon completion of this appeal process, if the employee is still not satisfied, formal appeal processes as indicated in the State of Montana Plan are then indicated.

Claims Processing Procedures

Claims for The State of Montana Employee Benefit Plan are initially examined and data entered by BCBS's Great Falls' 'front-end' personnel. This process performs an automated review of claim submissions. Claims that do not pass the automated system edits are suspended and assigned a code which identifies specific claims aspects to be reviewed. Claims documentation is then returned by courier to BCBS's Helena claims processing office.

On the following day, front-end claim entries appear on BCBS's Long Range System Planning (LRSP) claims adjudication system for review and final determination by Helena's Error Resolution Technicians. Helena has established separate divisions and responsibilities for the review of various claim edits, distributing claims by type of suspense code for review by appropriate BCBS staff (i.e., coordination of benefits, pre-existing conditions, accident information, duplicate edits, medical review, etc.). A single claim may be handled by multiple technicians depending on the number and type of suspension edits.

Error Resolution Manuals provide technicians with detailed explanation and instructions for the proper handling for each claims edit. By dividing error resolution responsibilities, technicians are able to become familiar with problems relevant to their specialty area of claims handling.

Utilization review (UR) responsibilities are also divided into specialty areas (i.e., precertification, large case management, hospital bill audits, and medical review). During these referrals, the claims are reviewed for other internal edits, such as review of supplies or durable medical equipment charges. It appears that during the system conversion period there were additional delays caused by multiple edits necessitating separate reviews by this department. BCBS has advised us that this practice has now been improved to allow for all reviews to be handled simultaneously. Due to the nature of the claims payment system much of the adjudication of claims is automatic, thereby reducing the need for technician intervention.

Subrogation\Third Party Liability

Subrogation recovery is a joint effort between BCBS and the Department of Administration. Initially, potential subrogation claims are identified by diagnosis code, accident report, and other insurance information provided on the claim submission and/or communication from the employee or provider. This information is then provided to the Recovery Unit in Great Falls which handles coordination of all subrogation claims.

When automobile medical coverage is known to exist, the system is noted to deny future claims related to the injury up to the maximum of the auto policy limits. Charges in excess of auto medical limits and all other subrogation claims are handled on a "pay and pursue" basis (claims are paid and then followed for reimbursement). The recovery unit notifies the employee of the State's right to recovery if the employee receives reimbursement for medical claims from the liable party.

The BCBS recovery unit may not notify the Department of Administration of all potential subrogation cases. In cases where the employee indicates there will be no legal pursuit, the claim is paid on a normal basis without notice to the State. We recommend that the State be advised of **all** claims involving third party liability, giving the option of pursuit relative to claims on which the employee has chosen not to take legal action.

Upon confirmation that a subrogation claim exists, the recovery unit informs the Department of Administration of such claim. At that time the Department, with their legal counsel, determines if this claim is worth pursuit. A statement is then obtained from the employee indicating that he/she has been fully compensated for the loss, and coordination between the employee's attorney and the State attorney continues until satisfactory settlement is achieved.

Subrogation information is maintained strictly by employee identification number at this time. A separate log identifying on-going or potential subrogation cases is not maintained by BCBS. Therefore, there is no way to actually track the number of third party liability cases in progress, or track as a group, the amount of recovery actually received. We recommend that a log be maintained by BCBS of all on-going and potential subrogation claims, and that this log be made available to the Department on a monthly basis for tracking purposes. The log should indicate the dollar amount of claims paid out and recovery received so the Department may adequately track the impact of statute 2-18-902 on the overall recovery of the Plan.

Contained within legislative sections 2-18-901 and 2-18-902 is the provision for the authority for subrogation and the procedures for the process of same. Within the 2-18-902 statute, recovery of medical payments is restrictive, as the employee must be 'fully compensated for his injuries'. This provision could also include loss of income, pain and suffering, and a number of other items which could be included in this determination; consequently, the process of subrogation may be inconsistent in the recovery of monies for this Plan.

Reimbursement Allowances

The State has elected to utilize BCBS's Schedule B allowances for determination of participating provider allowances. Participating providers write-off the difference between the amount billed and the scheduled allowance, relieving the patient from financial responsibility in excess of the deductible and/or coinsurance. When an in-state nonparticipating provider is utilized, the covered expense is based on the Schedule B allowance less an additional penalty variance of approximately 10%. In this case the patient has additional responsibility for the difference between the billed amount and BCBS's payment.

Out-of-state providers receive reimbursement according to the prevailing allowance applied to nonparticipating providers. If the charged amount exceeds the allowable by more than $100.00, the claim is automatically suspended by the system for additional review by the UR department. The UR department then contacts the regional BCBS office for the geographical area where services were rendered and obtains their allowance. The greater allowance is permitted for benefit calculations.

During the course of the audit, specific claims information was obtained for cross reference of geographic usual, customary and reasonable (UCR) calculations to determine if the expectations of the State are being met in this area. We concentrated on those claims which were for out-of-state providers. In most of these cases the patient does not have the choice of going to a participating provider for care. In one case a comprehensive office visit (CPT #99245) was billed in the amount of $360.00. Following UR determination of allowances for that area, BCBS reduced the allowable expense to $225 (a reduction of $135.00). However, in comparison with the equitable HIAA allowances, we found that $360.00 was the 90th percentile allowance. While BCBS is making their reimbursement allowances based on the requests of the State, we recommend that the Department be made aware of the extent of the impact on their employees as a result of the current guidelines relative to nonparticipating providers both in and out-of-state. It is unclear if the State is currently aware of the extent of the financial impact on their employees for utilization of these providers.

Maintenance of Fee Schedules and Provider Files

The Provider Relations Department works with those providers who are eligible to contract with BCBS, and as such has the authority to have changes made within the participating provider files. Database Maintenance (DBM) has the only authority to make actual changes on-line. Additions and updates to other provider files, as well as general provider maintenance, is limited to DBM.

A separate segment under the provider identification number indicates if a provider is a BCBS participating provider. The system then automatically calculates any appropriate discounts and applies the correct reimbursement schedule (Schedule B for State of Montana Employee Benefit Plan). Reimbursement files are updated and maintained by three separate departments: UR, PLASM, and Provider Relations.

Claims Processing System

The new processing system Long Range System Planning (LRSP) was implemented October, 1992. While this system change was not as smooth as anticipated, it appears that all necessary data has been either retained or carried forward to the new system for continuity in claims payment.

Use of passwords guaranty that access to the system is limited to only those functions necessary to perform individual duties. Possible security violations are monitored. Passwords are changed every 30 days. Personnel are required to log off when they leave their desk or work area. Within some areas of the system an automatic logoff is generated after a designated period of inactivity.

Employee payment histories were maintained on line for a period of 27 months under the prior system. BCBS has not yet determined how long on-line claim history files will be retained under LRSP; therefore, no information purge has been done. Microfilm documentation will continue to be retained indefinitely.

As previously indicated, the nature of the LRSP claims payment system provides automatic adjudication of claims, thereby reducing the need for technician intervention. Automated system edits include:

- duplicate payments edits for possible duplicate claim submissions;
- reduction for charges in excess of UCR;
- alerts for potential pre-existing conditions (based upon effective date of the member);
- identification of coordination of benefits through primary group plan; and
- identification of claims involving potential third party recovery.

Reports

Contained within the service agreement contract between The State of Montana and Blue Cross Blue Shield of Montana is a listing of reports to be provided to the State for purposes of tracking Plan activity and making comparative analysis based on prior years' activity. Report formats have changed as a result of the conversion process to the new LRSP system. In an effort to provide reliable information to the State, BCBS has tried to reformat the LRSP reports to a configuration similar to the information which they were receiving in prior years. While this formatting has been successful in providing broad spectrum claims experience information, it is unreliable with regards to the detailed information provided in these reports.

BCBS recognizes that this information (on the detail side only) is erroneous, and has attempted when possible to provide guidance to the State regarding how to best utilize the information provided for comparative purposes. While BCBS continues to provide all of the reports required within the agreement, in many cases this information is relatively useless for the purposes of the State.

BCBS is currently in the process of developing a new reporting system which they believe will be far superior than either the prior system or current format being utilized. This new system is expected to be implemented during the first quarter of 1995. Upon execution of this new system, BCBS has indicated they will be able to reformat all information from the time of the LRSP conversion in October, 1992.

While the State continues to have problems with the current reporting format, it appears that BCBS is attempting to correct the problems to the best of their current abilities. We recommend that BCBS continue to provide all possible guidance to the State in the understanding of these reports, provide information which is as reliable as possible, and continue to provide detailed updates to the Department regarding the progress on the new reporting system. While this additional assistance may be in excess of that normally provided to a client, we feel it is warranted since the problems have resulted directly from the BCBS conversion to a new system.

Financial Procedures

As previously indicated, claim drafts are issued on a weekly basis. The date of issuance depends upon the payee classification. Each week a report is generated from LRSP data to determine the amount of claims paid, and a telephone call is placed to the office of the State Treasurer requesting a wire transfer of funds to cover claims payments. This request is followed by a hard copy billing for claims paid. On a monthly basis, all weekly claim billings are balanced both by BCBS and the Department of Administration to ensure accuracy of all fund transfers.

Procedures are in place within the finance area of BCBS for proper accounting of uncashed, voided, and reissued drafts. Any uncashed drafts over 12 months old are considered to be abandoned property and are handled according to the escheat laws of the State of Montana.

Refund of overpayments made to participating providers are deducted directly from the provider's next batch draft. The provider's draft register identifies the reduction and the employee receives a copy of a new EOB with an explanation of the overpayment refund. A refund request letter is sent when an overpayment has been made to an allied provider or the employee. Two requests are sent at thirty day intervals. If after sixty days no response is received, the claim is referred to the collection committee for further action. According to BCBS, an average of six to ten refund requests letters are sent each week for the State of Montana Employee Benefit Plan.

Claim Control Measures

Our review confirms the following claim control measures utilized by BCBS for processing and payment of claims. These are consistent with those measures we have seen followed by other BCBS offices, insurance carriers and third party administrators.

- Administrative departments and units are based on specialty services.
- System access is limited through the use of passwords to specific functions required by an employee's job.
- Original claim documentation is reviewed to determine if the information provided is adequate to process the claim. As necessary, additional information is requested. Photocopies and incomplete documentation is verified with the provider of service.
- Error resolution manuals provide step-by-step instruction for adjudication of claims that do not clear automated system edits.
- Benefit limitations are applied as outlined in the Summary Plan Description.
- Automated reduction of submitted charges to appropriate UCR schedules.
- Inpatient hospital bills are reviewed by BCBS's UR department to determine if audit is warranted.
- Precertification authorizations are loaded directly into the utilization review (UR) system at the time of telephone inter-action between the UR department and the participant/provider. This system automatically interfaces with the LRSP claims system.
- Utilization review staff negotiates with providers who are requesting inpatient confinement for a procedure that can be performed on an out-patient basis to assure treatment is appropriate and cost effective.
- Potential large case management claims are automatically forwarded to the appropriate department for review and handling. Claims are identified by diagnosis

code, hospital stays of 7 days or longer, multiple (3 or more) hospital admissions during a 12 month period.

- System edits alert technicians to the potential for pre-existing conditions, coordination of benefits and claims involving third party liability.

- Provider edits identify services for review that may not be appropriate for the billing physician's specialty.

SECTION III

STATE ADMINISTRATION PROCEDURES REVIEW

The Department of Administration for the State of Montana has the inherent responsibility for compliance with legislative regulations and smooth coordination of health plan matters between the State and BCBS. Consequently, an integral part of our administrative critique included an onsite review of procedures utilized by the State's Department of Administration.

Our review was conducted on June 7, 1994. Interviews were held with personnel from the Employee Benefit Division and the State Treasury Department. We reviewed payroll deduction statements, premium billing statements and quarterly advisory council meeting notes.

List of Administrative Procedures Reviewed

The administrative review at the Department of Administration for the State of Montana focused on the following areas:

- Administrative Staff
- Enrollment and Eligibility
    - payroll deductions and coverage changes
    - previous coverage credit
    - cobra and self-payment documentation
    - information distribution to BCBS
- Financial Procedures
    - premium billings and reconciliation
    - electronic funds transfer
- Compliance With Legislative Regulations
- Subrogation

Within the scope of our audit services was a review of the applicable State of Montana regulations relating to the State Employee Benefits Plan. This review included an evaluation of the Department of Administration's procedures for coordinating administrative matters with BCBS to determine if they are within generally accepted practices.

Our review determined that the Department of Administration is in compliance with legislative regulations and that adequate administrative procedures have been established for

proper administration of the Plan. A few eligibility concerns which require the attention of the State and BCBS were identified. This section of our report discusses these matters and offers recommendations intended to improve overall efficiency and accuracy in the administration of the State Employee Benefits Plan.

Eligibility Review

A random sampling representing 20% of the claims audit selection (66 claims) was reviewed for appropriate determination of eligibility. Payroll records were checked against the service dates of the claims, as well as the appropriate employee/dependent payroll coverage deductions.

Payroll deductions for coverage are made in the prior month (i.e., deductions for September coverage are taken from August payroll). Self-payments are due on the first day of the month in which coverage is desired. COBRA payments are due by the last day of the month in which coverage is desired.

Dependent status (i.e., student status, adoption, divorce decrees, etc.) is verified by the Department of Administration. Copies of Change of Status Cards for addition or deletion of dependents are provided to BCBS. The Department is also responsible for the review of late entrant applications for enrollment and prior coverage credit. Following this review, the Department provides documentation to the participant regarding the rejection or approval of the application, and the effective date of current coverage or prior coverage credit. This information is also provided to BCBS via the monthly eligibility tape or other individual documentation.

BCBS does not terminate member eligibility until hard copy documentation has been received from the State. Should a retro-active termination date be received by BCBS, Member Accounting coordinates efforts with Customer Service to determine if claims have been received and paid. As appropriate, overpayments are then requested.

BCBS produces a report which identifies discrepancies in specific member eligibility. This report is sent to the Department of Administration for review and correction. Currently this report is being reviewed by the State on an 'as time permits' basis. However, while this review is taking place at the State, BCBS continues to process claims for those participants who appear on this discrepancy listing. We recommend that BCBS suspend claim processing on all participants who appear on this listing until such time as the State reconciles the report to determine appropriateness of coverage and that the State assign this as a top priority item to avoid payment of ineligible claims.

- Maintenance of Payroll Records

  The State maintains payroll records on microfilm. During our review we encountered difficulties with the microfilm for two months:

  - August, 1992 microfilm could not be located. As a result, eligibility could not be verified by State records for claims with a September, 1992 incurred date.

  - January, 1993 microfilm was erroneously labeled as February, 1993. It was explained that there had been a delay in microfilming and that a new State employee had inadvertently labeled the information sent to the microfilm vendor with an incorrect date.

    This incorrect labeling prompted a review of an individual's eligibility. Upon further investigation at both BCBS and the State, it was confirmed that claims had only been paid during month's of coverage. Claims submitted subsequent to the break in coverage were investigated by BCBS for relevant pre-existing conditions and appeared to have been adjudicated appropriately.

- Notice of Coverage Termination

  Recent employee benefit terminations were requested from the Department to enable a cross verification with BCBS records. We were given information regarding four self-payment terminations. Discrepancies between State and BCBS records were found in three employee files, the fourth was consistent in both data files. The results of our investigation are indicated below:

Explanation - Termination #1	State	BCBS
Effective date for current status (retiree)	11/01/93	12/01/93
Last self-payment	02/04/94 February coverage	
Termination	02/28/94	03/31/94
Information for this employee's transfer to retiree status was received by BCBS on the November, 1993 eligibility tape and should have been effective 11/1/93. The BCBS termination date was also incorrect. The Department failed to terminate this employee from the active tape until April, 1994. Premium payment level was correct.		

Explanation - Termination #2	State	BCBS
Effective date for current status (self-pay)	09/01/93	09/01/93
Last self-payment	02/01/94 February coverage	
Termination	02/28/94	02/28/94
All information, including premium payment level was correct.		

Explanation - Termination #3	State	BCBS
Effective date for current status (self-pay)	08/01/83	09/01/91
Last self-payment	02/01/94 February coverage	
Termination	02/28/94	Active, Paid to 06/01/94

The premium payment level was found to be correct. The differential in effective dates was due to a status change on 09/01/91 for primary coverage by Medicare and is correct.

A letter requesting termination of coverage was sent by the employee to BCBS, and a copy forwarded to the State. Coverage was terminated and no further premium payments were made. A telephone call from the employee's daughter was later received by the State indicating this was in error and requesting reinstatement. The State then notified BCBS by telephone, to reinstate coverage and reconsider previously denied claims. BCBS complied with this request. The State failed to create a new self-payment card or add this participant back onto the active eligibility tape. This resulted in no additional premium payments being collected, even though the member was in fact receiving benefits.

Explanation - Termination #4	State	BCBS
Effective date for current status (self-pay)	07/01/93	07/01/93
Last self-payment	01/07/94 January coverage	
Termination	01/31/94	Active, Paid to 06/01/94
During the period of premium payments, the level of premium was found to be correct for the type of coverage indicated. The State canceled coverage for this employee on the February, 1994 eligibility tape. BCBS showed this employee on the exceptions report effective April, 1994. Because the listing was not reconciled by the State and BCBS did not receive hard copy documentation of the termination date, coverage was not terminated in the system and the employee continues to show valid eligibility.		

As clearly indicated in the above examples, eligibility terminations provide an area of major concern. Because the tracking of self-payment and COBRA premium payments is primarily a manual procedure by the State, there is room for human error. When an employee fails to show on an eligibility tape sent by the State to BCBS, that employee appears on a monthly exceptions listing produced by BCBS which is then forwarded to the State for reconciliation. BCBS requires a hard copy of the actual termination date from the State prior to terminating coverage. This BCBS procedure is to assure that employees who have been dropped from the State tape in error are not penalized. During this reconciliation time, employees continue to receive coverage and could conceivably receive claim payments when they should no longer be eligible under the State Plan.

We recommend that all employees shown on the BCBS exceptions listing be suspended from coverage eligibility until notification by the State of the status of coverage. This would eliminate the possibility of claims being paid for a participant who's coverage has been terminated.

The State advised that a new payroll system will be implemented in the near future. It appears that this new system will be capable of a head-to-head eligibility reconciliation. We recommend that a complete data coverage reconciliation be conducted at the time the new system goes on-line with special emphasis on the self-payment and COBRA participants. We further recommend that this reconciliation continue to be performed at least quarterly to verify the new system's capabilities. We believe that this will enable the confirmation/correction process to be handled in a more timely manner. This system should also be able to detect errors or omissions by either the State or BCBS, thereby eliminating the type of problems encountered in this review.

Premium Billings

Premium billings for each month of the audit period were reviewed while at the Department of Administration. Discrepancies were found in both the June and July 1993 billings due to a manually entered calculation in the State's Lotus program. The June 1993 billing was paid correctly, however, the July entry resulted in a variance of $8.40 which was subsequently corrected. These billings are forwarded to BCBS with a check for the appropriate premium amounts. BCBS then returns a copy of their billing indicating receipt of the State's payment.

The administrative billing which BCBS prepares for the State is based solely on the figures which the State provides. BCBS does not check the number of participants which the State has paid administration fees on against the number of participants actually shown as covered in their system.

This may result in administration fees not being paid for eligible participants who do not appear on the State's eligibility tape. There is no system currently in place for recovery of unbilled administration fees when a person is not actually terminated. The new payroll system should enable a more efficient method of handling these discrepancies.

Legislative Review

The scope of our services included a review of the State of Montana regulations relating to the State Employee Benefits Plan and a determination of the Department of Administration's compliance with these regulations. We reviewed sections 2-18-701 through 2-18-704, 2-18-808 through 2-18-816, and 2-18-901 through 2-18-902 M.C.A. (Montana State Law).

To assure compliance with these legislative regulations, an onsite review was conducted at the State office on June 7, 1994. Interviews were held with personnel from the Employee Benefit Division and the State Treasury Department. We reviewed payroll deduction statements, premium billing statements and quarterly advisory council meeting notes.

During the course of this review we found the State to be in compliance with all relevant regulations. Following is a brief summary of the topics contained in these specific regulations.

701	Coverage provided for each class of eligible employee.
702	Premium deductions from employee compensation.
703	Agency contributions.
704	Mandatory provisions for continued coverage for specific eligible members and dependents.
808	Establishment of provision for adequate affordable group benefits for eligible state employees.
809	Defines terminology relative to State Employee Benefits Plan.
810	Department consultation with the advisory council prior to plan changes. Quarterly advisory council meetings to review and advise on state employee group benefit matters.
811	Adoption of rules for conduct of business and utilization of same. Negotiate and administer contracts for State plans. Design plans, establish bids, recommend acceptance or rejection of such bids. Prepare, or have prepared, an annual report. Perform or obtain a rate adequacy analysis prior to each legislative session. Submit rate analysis report to the State budget offices.
812	Establishment of alternatives to conventional insurance. Maintenance of funding.
813	Does not directly address the Department's activities at this time relative to the audited State Employee Benefits Plan.
814	Appropriate administrative expenditures included in the costs for state employee group benefits.
815	Does not directly address the Department's activities at this time relative to the audited State Employee Benefits Plan.
816	Biennial audit of the State benefit plan.
901	Provisions for the legal authority to subrogate under the plan.
902	Provisions for enforcement of subrogation.

SECTION IV

BCBS CLAIMS AUDIT REVIEW

As directed by the Office of the Legislative Auditor, our report examines three separate claim processing periods: March 1, 1992 through September 30, 1992; October 1 through December 31, 1992; and January 1, 1993 through February 28, 1994. One hundred ten (110) claims transactions processed and paid on behalf of members and their dependents were selected from each audit period.

For purposes of this audit, a transaction is defined as any claim form, bill or other documentation processed for payment under one unique claim number. The claim number assigned to each transaction was used as the basis for selection of claims to be audited. The terms 'transaction' and 'claims' are synonymous.

Elements of Individual Claim Review

Our evaluation of claims selected for audit included examination of claims history, deductibles and coinsurance percentages as applicable. In addition to verifying the amount paid, the audit included a review to determine the following:

- Claims were paid in strict accordance with the provisions of the Plan.
- Amounts paid were within the designated reasonable and customary allowances and/or preferred provider network fees for the area where treatment was rendered, with due consideration for the severity of the condition treated, based on schedules utilized. Our audit did not include a review for medical necessity.
- Claims were paid only on behalf of eligible individuals, based on eligibility data contained in the claims system.
- Claim forms, as applicable, were adequately completed with all data necessary to properly process the claim.
- Documentation (provider bills, physician statements, utilization review findings, surgical reports, etc.) was on file for claims paid and verified when necessary.
- Benefits were paid under the proper benefit classification, diagnostic and procedure codes.
- Appropriate benefit limitations, deductibles, coinsurance and out-of-pocket maximums were applied, as applicable.
- Arithmetic calculations were correct.

- Coordination of benefits, subrogation and pre-existing provisions were enforced, as applicable.

- Duplicate claims were properly denied.

- Payment was made to the proper party.

- Turnaround time was within acceptable standards for processing of claims from receipt to check mail out date for member and nonmember physicians, and the explanation of benefits mail out and check mail out date for member physicians.

Selection of Claims

The sample of claims selected for examination was stratified by dollar amount to give large claims more valid representation in the sample. Because the greater percentage of claims processed in most plans represents a nominal dollar value of individual and collective benefit payments, a pure random selection cannot assure that claims will be selected from all types of benefits or provide valid representation of higher claims payments that may require additional review and/or expertise.

The methodology of our stratified selection process utilizes formulae designed to take full advantage of statistical sampling procedures that allow us to have a quantifiable degree of confidence that the results obtained in our audit sample are a true reflection of the actual way all claims were processed.

Determination of Errors

Processing errors are classified as 'payment' or 'procedural'; procedural errors do not involve a variance in payment. Claims containing multiple errors are only counted as one error in determining the accuracy levels achieved in this report. If a payment error also contains a procedural error, it is counted as a payment error. Claims requiring additional investigation prior to confirmation of a payment error are counted as procedural errors and noted as possible payment errors.

All errors were reviewed and discussed daily with the Internal Audit Division of Blue Cross Blue Shield of Montana. Copies of all audit worksheets containing errors and/or comment were provided to BCBS prior to our completion of the onsite audit.

Processing Accuracy

A total of 330 claims were selected for audit, 110 for each of three audit periods. The following table summarizes our finding which have been adjusted for stratification.

	March 1, 1992 - September 30, 1992	October 1, 1992 - December 31, 1992	January 1, 1993 - February 28, 1994
Claims Free From All Errors	99.7%	92.4%	99.6%
Financial Accuracy	99.7%	98.7%	98.9%
Total Dollar Audited	$1,059,317.95	$593,321.12	$1,176,708.25

Payment and procedural errors are categorized by type of error below. Detailed explanations are provided at the end of this section.

Category of Error	March 1, 1992 - September 30, 1992	October 1, 1992 - December 31, 1992	January 1, 1993 - February 28, 1994
Hospital Miscellaneous Expenses	7	4	6
Benefit Application	1	4	2
Noncovered Services	-	4	1
Private Room Charge	-	4	1
Date Entry	1	2	2
Coordination of Benefits	1	1	-
Calculation of Allowable Expense	1	1	-
Pre-existing Condition	-	-	1
Investigation/ Documentation	-	-	1
TOTAL	11	20	14

MARCH 1, 1992 through SEPTEMBER 30, 1992

Item #	Over/(Under) Payment	Explanation
61	NA	Calculation for claim involving coordination of benefits included noncovered prescription (nicoderm), resulting in overstatement to COB savings reflected in the system.
71	4.75	Hospital slippers paid in error.
72	(218.70)	Claims for chemical dependency were denied prior to exhaustion of maximum benefit payment.
73	(254.31)	Provider discount applied during nonmember provider status.
76	25.16	Hospital maternity admission and father's kits paid in error.
96	4.10	Hospital slippers paid in error.
97	6.10	Personal care items during hospital confinement paid in error.
98	(.01)	Incorrect data entry of billed amount.
107	8.00	Hospital slippers and shampoo paid in error.
109	12.00	Hospital expense for kleenex paid in error.
110	25.70	Hospital personal care items (shampoo, mouthwash, kleenex) paid in error.

Procedural Errors:	One (1)
Payment Errors:	Ten (10) Total $558.83 7 Overpayments ($85.81) 3 Underpayments ($473.02)

OCTOBER 1, 1992 through DECEMBER 31, 1992

Item #	Over/(Under) Payment	Explanation
13	NA	Incorrect date of service.
22	16.87	Noncovered expense (aerochamber) paid in error.
30	(1.50)	Incorrect determination of allowance for chiropractic visit with manipulation.
51	(52.50)	Emergency room charge for myocardial infarction secondary to other disorders of soft tissues was denied. BCBS disagrees stating the diagnosis did not indicate a medical emergency.
65	(69.50)	Hospital observation room charge for oncology was denied in error.
72	14.22	Hospital father's kit paid in error. Incorrect benefit code.
75	(3,144.60)	Incorrect calculation of BCBS benefit payment primary to Medicare.
76	24.24	Nicotine patches were paid in error.
79	4.15	Hospital slippers paid in error.
81	275.00	Private room charge paid in error. BCBS has indicated that the system was not updated at the time this claim was paid.
82	(162.51)	Incorrect calculation of coinsurance level resulted in $192.00 underpayment. Incorrect billed amount resulted in $29.49 overpayment.
84	(45.75)	Separate hospital expense for observation room should be combined with the room charge, limiting total reimbursement to the average semi-private allowance. BCBS disagrees stating the separate observation charge on the same day as a charge for room and board should be denied as inclusive of the room.
86	6.00	Private room charge paid in error. BCBS has indicated that this is a system error, semi-private allowance was not updated at the time this claim was paid.
87	25.00	Private room charge paid in error.
92	4.80	Hospital personal care items (toothpaste, toothbrush, comb) paid in error.
96	4.95	Hospital slippers paid in error.

Item #	Over/(Under) Payment	Explanation
99	58.00	Occupational therapy paid in error.
100	NA	Incorrect data entry of billed amount.
104	14.00	Private room charge paid in error. BCBS has indicated that this is a system error, semi-private allowance was not updated at the time this claim was paid.
109	20.00	Charge for utilization review paid in error.
Procedural Errors:		Two (2)
Payment Errors:		Eighteen (18) Total $3,943.59 12 Overpayments ($467.23) 6 Underpayments ($3,476.36)

JANUARY 1, 1993 through FEBRUARY 28, 1994

Item #	Over/(Under) Payment	Explanation
50	(.05)	Incorrect data entry of other insurance carrier's payment.
61	(125.45)	System coding error resulted in benefit cut back.
64	(32.22)	Incremental nursing service were denied in error.
68	2,348.66	Pre-existing condition was not identified on the system allowing the charges to be paid in error.
80	40.10	Hospital personal care items were paid in error.
85	25.00	Hospital expense for 'book' was paid in error.
86	NA	Incomplete investigation of 'other treatment room'. Records require review to determine if the expense would be considered as a recovery room. Possible underpayment of $223.10.
87	47.87	Occupational therapy paid in error.
91	(13.75)	Incorrect data entry of billed amount.
97	8.10	Hospital personal care items paid in error.
99	825.00	Private room charge paid in error.
102	17.94	Hospital admission kit and pacifiers paid in error.
108	14.30	Hospital admission kit paid in error.
110	632.00	Hospital charge for nutritional re-evaluation paid in error.

Procedural Errors:	One (1)
Payment Errors:	Thirteen (13) Total $4,130.44 9 Overpayment ($3,958.97) 4 Underpayment ($171.47)

Other Claim Matters

The following claim matters have been identified as areas of concern. They were not included in the error calculations of this report because they were processed correctly according to BCBS administrative procedures in place at the time. These claims are included to highlight recommendations for possible implementation.

- Hospital Discount Agreement

  BCBS has indicated that their contractual agreement with Rivendell Hospital provides for a discount of the total billed charges without exclusion of noncovered charges. Our review included a charge for 'nutritional analysis' ($61.20 payment) which would otherwise be denied under the Plan. We encourage BCBS to revise this contract, making the employee wholly responsible for noncovered expenses and providing a discount based on the State's allowable expense. (Worksheet 89, processed June, 1992)

- Injections

  Physicians have been instructed to bill injections separately for their administration fee and drug charges. If the name of the drug is submitted, the charge is paid under the prescription benefit code which may be subject to the lesser coinsurance level for brand name drugs. This practice allows for inconsistent benefit reimbursement of injection expenses billed by providers. Standard industry procedures consider the drug and administration fee as one charge, payable at the major medical coinsurance level. (Worksheet 18, processed January, 1994)

  BCBS indicates that this procedure allows the system to deny the administration fee if there is a corresponding office call, or to pay the lower administration fee if no office call is necessary.

- Mental/Nervous ICD9 Codes

  An amendment, effective September 1, 1992, identified certain ICD9 diagnosis codes that are not covered by the State Plan. BCBS indicated that the system was modified in April, 1993 and that a report was sent to the State requesting instructions for handling identified payment errors. It is our understanding that the State did not respond to the request, and that BCBS did not pursue a response. Because the $1,417.50 overpayment identified in our audit was included in the report to the State, the claim was not considered to be in error for purposes of this report. The State should review this report and provide BCBS with handling instructions. (Worksheet 94, processed November, 1992)

- Prescription Drugs

  BCBS was consistent in the processing of prescription drug charges. However, two administration procedures were determined to provide a higher level of reimbursement than noted in similar provisions found within the insurance industry. Our comments are provided for the State's consideration:

  - Brand Name Drugs are reimbursed at 70% after the deductible, whereas generic drugs are payable at 90% after the deductible. Once the individual has incurred $3,000 of allowable charges in the benefit year, **all** covered prescriptions are reimbursed at 100%. Therefore, the incentive to seek generic drugs is eliminated once the 20% coinsurance differential has been removed. Many plans continue to apply this 20% differential to the coinsurance level otherwise payable.

  - Take Home Drugs received upon discharge from a hospital confinement are reimbursed as an inpatient hospital expense and paid at 75%. Most plans isolate this expense, reimbursing benefits at the lower brand name coinsurance (i.e., 70%).

- Other Payment Error

  Manual calculation of the number of inpatient days for a mental/nervous condition contributed to the overpayment of 2 days within the benefit year. We recommend that this file be reviewed and the appropriate overpayment requested. (Worksheet 74, processed March, 1992 - This error was not on the claim selected for audit but occurred on claim #13385518.)

Turnaround Time Analysis

The insurance industry has established 10 to 14 business days as an acceptable standard for prompt handling of claims. Turnaround time is calculated from the date all documentation required for benefit consideration was received to the date the claim was processed for payment or denial. This analysis includes routine delays due to internal review for medical necessity, audit, etc. and excludes delays realized in the issuance of drafts on a scheduled basis.

Turnaround time has been analyzed individually for each of the three audit periods. As requested by the State, our report provides three calculations:

- Mean - the date midway between the earliest and latest values in the date range;

- Mode - the number of days within the date range which indicates the greatest number of claims processed; and

- Median - the specific date within the date range at which 50% of the claims were processed prior and 50% processed after that specified date.

Method of Calculation	March 1, 1992 - September 30, 1992	October 1, 1992 - December 31, 1992	January 1, 1993 - February 28, 1994
Mean	11.9	18.6	17.6
Mode	2	4, 6 & 25	3
Median	7	15	7

Industry standards utilize the mean average in determining compliance with the established 10 to 14 business days for processing complete claims. As indicated in the above table, the first audit period is within the acceptable range, however, claims processed in the second and third audit periods are slightly higher.

A claim received on October 9, 1992 required review at several levels (i.e., durable medical equipment, medical supplies, duplicate checking, accident investigation). Time required to submit the claim to various levels of review resulted in a delay of benefit payment until November 11, 1992. BCBS has taken measures to reduce multiple stages of review that may cause unnecessary delays in processing. Currently, multiple claim edits are resolved during evaluation by Utilization Review nurses. A detailed summary of the turnaround time for each audit period is shown at the end of this section.

Variances for Draft Issuance

In many automated claims operations, there may be a variance between the date a claim is processed and the date the draft is produced by the system. This is done primarily to accommodate efficient draft production and mailing. This is a common practice in the industry today and is not unique to BCBS. While not uncommon, it is important to note that some time parameters between claim processing and draft production dates may be unacceptable to the group, employees and/or providers of service.

BCBS issues all benefit payments weekly. The draft distribution schedule is detailed below:

Monday	PPO providers and participating hospitals

Tuesday & Thursday	Employee EOBs for PPO/participating providers Employee drafts Allied providers with assignment
Friday	Participating physicians

Using the above production schedule, the maximum time delay after processing would be 5 days, with the majority distributed in less time. A review of the claims audited indicates that these time parameters are being met on a consistent basis.

MARCH 1, 1992 through SEPTEMBER 30, 1992

Days	Number	Percent	Cumulative %
0	6	5.45%	5.45%
1	4	3.64%	9.09%
2	13	11.82%	20.91%
3	4	3.64%	24.55%
4	6	5.45%	30.00%
5	7	6.36%	36.36%
6	7	6.36%	42.73%
7	7	6.36%	49.09%
8	6	5.45%	54.55%
9	7	6.36%	60.91%
10	1	0.91%	61.82%
11	5	4.55%	66.36%
12	2	1.82%	68.18%
13	6	5.45%	73.64%
14	0	0.00%	73.64%
15	2	1.82%	75.45%
16	1	0.91%	76.36%
17	1	0.91%	77.27%
18	3	2.73%	80.00%
19	3	2.73%	82.73%
20	1	0.91%	83.64%
21	2	1.82%	85.45%
22	1	0.91%	86.36%
23	1	0.91%	87.27%
24	0	0.00%	87.27%
25	2	1.82%	89.09%
26	1	0.91%	90.00%
31	1	0.91%	90.91%
30	1	0.91%	91.82%
32	1	0.91%	92.73%
38	3	2.73%	95.45%
49	1	0.91%	96.36%
51	1	0.91%	97.27%
54	1	0.91%	98.18%
57	1	0.91%	99.09%
68	1	0.91%	100.00%
TOTAL	**110**	**100.00%**	

MARCH 1, 1992 through SEPTEMBER 30, 1992

Days	Number	Percent	Cumulative %
1	4	3.67%	3.67%
2	5	4.59%	8.26%
3	2	1.83%	10.09%
4	6	5.50%	15.60%
5	3	2.75%	18.35%
6	6	5.50%	23.85%
7	4	3.67%	27.52%
8	4	3.67%	31.19%
9	3	2.75%	33.94%
10	3	2.75%	36.70%
11	5	4.59%	41.28%
12	3	2.75%	44.04%
13	3	2.75%	46.79%
14	1	0.92%	47.71%
15	3	2.75%	50.46%
16	3	2.75%	53.21%
17	5	4.59%	57.80%
18	3	2.75%	60.55%
19	4	3.67%	64.22%
20	2	1.83%	66.06%
21	1	0.92%	66.97%
22	1	0.92%	67.89%
23	2	1.83%	69.72%
25	6	5.50%	75.23%
26	4	3.67%	78.90%
27	2	1.83%	80.73%
28	3	2.75%	83.49%
29	1	0.92%	84.40%
32	2	1.83%	86.24%
33	2	1.83%	88.07%
34	2	1.83%	89.91%
35	1	0.92%	90.83%
37	1	0.92%	91.74%
40	1	0.92%	92.66%
42	1	0.92%	93.58%
45	1	0.92%	94.50%
50	1	0.92%	95.41%
51	1	0.92%	96.33%
54	1	0.92%	97.25%
70	1	0.92%	98.17%
75	1	0.92%	99.08%
115	1	0.92%	100.00%
TOTAL*	**109**	**100.00%**	

* Could not determine received date for one claim in the selection period

MARCH 1, 1992 through SEPTEMBER 30, 1992

Days	Number	Percent	Cumulative %
0	1	0.91%	0.91%
1	5	4.55%	5.45%
2	11	10.00%	15.45%
3	15	13.64%	29.09%
4	9	8.18%	37.27%
5	5	4.55%	41.82%
6	2	1.82%	43.64%
7	3	2.73%	46.36%
8	7	6.36%	52.73%
9	5	4.55%	57.27%
10	1	0.91%	58.18%
11	4	3.64%	61.82%
12	4	3.64%	65.45%
13	1	0.91%	66.36%
14	1	0.91%	67.27%
15	1	0.91%	68.18%
16	1	0.91%	69.09%
17	5	4.55%	73.64%
18	1	0.91%	74.55%
19	1	0.91%	75.45%
20	1	0.91%	76.36%
21	0	0.00%	76.36%
22	1	0.91%	77.27%
23	2	1.82%	79.09%
24	1	0.91%	80.00%
25	4	3.64%	83.64%
26	1	0.91%	84.55%
31	1	0.91%	85.45%
32	1	0.91%	86.36%
38	1	0.91%	87.27%
42	1	0.91%	88.18%
44	1	0.91%	89.09%
46	1	0.91%	90.00%
49	1	0.91%	90.91%
54	1	0.91%	91.82%
55	2	1.82%	93.64%
57	1	0.91%	94.55%
85	1	0.91%	95.45%
90	1	0.91%	96.36%
92	1	0.91%	97.27%
104	1	0.91%	98.18%
112	1	0.91%	99.09%
167	1	0.91%	100.00%
TOTAL	**110**	**100.00%**	

Confirmation of Benefit Payments

Notices requesting confirmation of payment of benefits were sent for 20% of the claims audited (66 claims). Recipients were advised that The Segal Company had been retained by the State of Montana to perform a routine examination of claims processed by Blue Cross Blue Shield of Montana. Individuals were asked to certify the authenticity of information identified during our review. Self-addressed, stamped envelopes were provided for their response.

Only 33 responses were returned from our initial request; 14 additional responses were received subsequent to our second mailing. Phone calls were attempted to the remaining participants. We were successful in obtaining 7 responses, 4 employees had terminated employment and could not be located.

Based on the responses received, we did not find cause to question the validity of these claims. Our analysis is summarized below:

63%	Verified that the claim information was correct.
20%	Indicated that the claim information appeared to be correct but could
13%	Indicated that they were unable to verify the information due to the
4%	Indicated the payment was correct but noted a discrepancy in the

Claims Tests

The Legislative Auditor, in their Request For Proposals, identified certain claims tests to be performed that would assure proper measures are in place for accurate administration of their plan benefits. Additional test claims were identified by Segal.

Claims identified for this review were input by employees of BCBS at the direction of our audit staff. Each claim was entered into the front-end system and again onto the claims adjudication system (LRSP). This process allowed our staff to analyze all phases of claims processing, reviewing edits from both processing levels. BCBS took appropriate measures to assure that claims payments were not released.

Edits were detected on both levels of system processing. Initial data entry (front-end) both identified certain claims for specific handling and sent other claims to the LRSP system with suspend codes. The findings noted below reflect the final status of benefit determination.

- Logic Claims Tests

  At the State's direction, a fictitious claim for a covered individual was processed then resubmitted after modifying:

  - the diagnosis code - denied as a duplicate claim submission
  - the amount billed - suspended for investigation of potential duplicate claim
  - the provider code - suspended for investigation of potential duplicate claim.

  Three additional test claims were resubmitted after modifying:

  - the procedure number - suspended for further investigation of possible duplicate
  - the place of service - denied as a duplicate claim submission
  - the date of service - paid the claim with no suspension edits

  The procedure number we entered for modification of the service date (item 3 above) could conceivably be performed multiple times. Accordingly, an additional test claim was input using a procedure code which could only be performed once (hysterectomy). Although the system denied this claim when the date was changed, the denial was made on the basis of a lifetime maximum for the procedure itself, not because this was a potentially duplicate claim.

  The State had also requested a test for modification to the type of service. However, the test was not performed because the new LRSP system no longer utilizes a type of service code. The omission of this code does not appear to adversely affect claims processing.

- Claim Denials

  Our sample tests indicate that the system can detect and deny benefits for the following claim submissions:

  - Assistant surgeon expense for unnecessary procedure
  - Dependent who's coverage is no longer in effect based on BCBS eligibility records
  - Duplicate submission by member and provider
  - Expenses not covered by the Plan

- Experimental procedure
- Employee who's coverage is no longer in effect based on BCBS eligibility records
- Previously processed claims resubmitted for payment without modification.

- Suspense Edits

The following claims were suspended through system edits and referred to the appropriate department(s) for further investigation:

- Cosmetic procedures
- Diagnosis for potential large case management review (cases are noted on the system following identification through the UR department, customer service, employee or provider contact). Claims are not automatically identified by ICD9 (diagnosis) code.
- Expenses paid or covered by another insurer
- Inpatient hospital claim requiring pre-certification (suspended to Utilization Review for retrospective review when Managed Care information was not previously loaded in the system)
- Multiple surgical procedures same day, different operative field
- Potential pre-existing condition for new dependent (based on effective date of coverage and date services were rendered)
- Potential pre-existing condition for new employee (based on effective date of coverage and date services were rendered)
- Procedure not consistent with the age of the patient - Our initial claim was for a procedure which BCBS had no established age guidelines (female sterilization, age 14). Consequently, the system allowed the claim to process without edit. A second claim was then tested for a procedure which was age specific as indicated in the CPT coding. This claim was suspended by the system for inappropriate coding.
- Procedures not consistent with the sex of the patient

- Determination of Allowable Expense

  - Data base test - The system applied appropriate UCR for this provider based on Schedule B allowances. In addition, nonparticipating allowances and assistant surgical allowances were cross-checked.

  - Office visits following surgery - The system incorporated allowances into the global fee and allowed or denied the procedures based on the appropriate UCR allowances.

- Potential Concerns

  - Fragmented laboratory expenses - The system paid all charges based on the procedure codes billed. BCBS is not currently utilizing system edits for fragmented/unbundled lab charges, although edits are available in this area.

  - Multiple surgical procedures same day, same operative field - Four surgical procedures were individually input; the main procedure was payable and all other charges should have been indicated as inclusive and combined with the main allowance. The BCBS system paid the main procedure, denied one of the subsequent procedures and paid the remaining two procedures at 50% resulting in an excess allowance of $300.00. BCBS has indicated that this was the result of a data base error in the loading of these particular procedure codes and has advised that appropriate corrections have been made.

  - New patient CPT (procedure) codes for an established patient - The system paid appropriate UCR allowances based on procedure code billed. BCBS is not currently utilizing system edits for tracking upcoded office visits from established to new patient, although edits are available in this area.

- Prior Audit Concerns

The November, 1992 audit report prepared by Wolcott & Associates, Inc. addressed two primary areas of concern resulting from their claims tests. Our review included multiple claims tests for each area of concern as follows:

  - Fictitious provider - As indicated in the section of the report headed "Prior Audit Recommendations" the system was enhanced to lower the previous investigation amount on out-of-state providers to $300.00. The system will suspend claim payments when draft issuance exceeds $300.00 for a particular claim. However, no suspension or investigation is implemented when the bill is not assigned for payment directly to the provider of service. Additionally, it was unclear at the time of our tests if the system would provide a 'running total' of multiple small claims received for a provider who had not been investigated and if investigation would then commence when total claims paid exceeded the $300.00 attachment point.

- Services inconsistent with patient's sex - Our review included two tests which were gender specific for females, three additional were specific for males. The system suspended each claim for investigation of inappropriate coding.

- Recommendations:

Based on the above indicated claims tests we make the following recommendations:

- BCBS should utilize full system capabilities for detection and re-coding of fragmented or unbundled expenses. When providers "unbundle" their charges they are able to receive a larger benefit than when appropriate global fee coding is utilized. We find this to be an area of growing concern throughout the claims paying industry, especially as it relates to laboratory expenses.

- BCBS should utilize full system capabilities to track physicians charging multiple "new" patient exams for established patients in order to obtain a greater benefit. While BCBS's UR department performed a detailed study on 'upcoding' (the practice of charging for more intensive procedures than were actually performed), our information while onsite indicated that this investigation concentrated on coding for appropriate length and intensity of the visit. When an 'upcoded' charge is noted, the billing should be recoded by the UR department, or simply returned to the physician for corrected billing.

- BCBS should review the system's data base to determine that multiple surgical procedures are being adjudicated correctly. This could become a very time intensive process. Ideally, multiple surgical procedures should be flagged for UR review prior to payment. As an alternative, a retrospective review could be performed quarterly for all multiple surgical procedures processed by the system since the prior review.

- As previously indicated, we recommend that the out-of-state provider investigation threshold of $300.00 be expanded to include investigation of those claims which are not assigned for provider payment. This would put in place another check-and-balance in the ongoing concern of detection of possible fraud and abuse under all claims payment Plans.

SECTION V
PRIOR AUDIT RECOMMENDATIONS

Wolcott & Associates, Inc. performed an audit of the State Employee Benefit Plan for the period March 1, 1990 through February 29, 1992. Their report, issued in November, 1992, contained 11 recommendations. Following is an abstract of each recommendation and the Department of Administration's November 9, 1992 response to Wolcott and Associates, Inc. As appropriate, our comments and recommendations have been included.

1. **New System Audit**

   Wolcott: The State's plan will soon be converted to the new BCBS computer system. We recommend that an interim audit be performed as soon after the conversion in order to assess the system's ability to accurately process plan claims.

   State: Although an audit of the new system was desirable, the budget did not include an interim audit.

   Resolution: No outside audit was performed at the time of the system conversion. BCBS continued with regular internal audits for identification of possible system problems.

2. **Out-of State Providers**

   Wolcott: We recommend the system's threshold for seeking data for out-of-state providers be lowered to $50.00 in order to reduce the risk of fraudulent claims and to verify reasonable fee levels.

   State: Although the measures suggested are desirable, they require a manual process that can drive up claims administration costs if done in large numbers. Cost effective alternative will be explored with BCBS.

   Resolution: Following discussions between the Department and BCBS the threshold for seeking data was dropped from $500.00 and $600.00 for physicians and supplies, respectively, to $300.00 for all out-of-state providers.

   Segal: During the course of our audit it was noted that there is a $300.00 "payment" amount but claims are only investigated when the payment is assigned to the provider of service. A claim could be submitted by an employee indicating an out-of-state provider for services in excess of $300.00 with no assignment of benefits to the provider and payable to the member. No procedure is in place to verify that the claim is in fact a legitimate claim from a viable provider. The potential for

submissions of fraudulent claims still exists. We recommend that the data seeking threshold of $300.00 for out-of-state providers be expanded to include provider investigation on nonassigned claims.

3. **Procedure Codes**

Wolcott: We recommend BCBS review the procedure codes and assure that all gender specific codes will cause claim processing to suspend in the event that the code and patient's sex are inconsistent.

State: We concur and understand from BCBS this has been accomplished.

Resolution: BCBS has reviewed the system and advises that all gender specific codes are now loaded appropriately.

4. **Duplicate Claims Edits**

Wolcott: We recommend the language for automatic duplicate claim rejection notices be softened for situations where the claim may actually not be a duplicate.

State: We concur and understand that the denial was related to a 'Lifetime Procedure Table' for which second procedures are automatically denied.

Resolution: The general system for duplicate edits was not a problem. However, the system has been corrected for determination of lifetime procedure denials. This correction included a review of the database and the new system capability for tracking bilateral procedures with "right" and "left" designations.

5. **Managed Care Montana**

Wolcott: We recommend that Managed Care Montana: (1) implement an effective accounting system and (2) develop a method of estimating the value of averted costs that is more reflective of the cost of services not performed.

State: We concur with implementation of an effective accounting system. We will further assess industry norms, the impact of BCBS procedures and the need for a change in measuring the value of averted costs.

Resolution: Managed Care Montana has implemented a thorough and effective accounting system. The new upgrade involves use of an accounting module on which the Case Managers directly record their billable time spent handling cases. Information is also written in manual files, and is periodically downloaded into the P.C. environment where data is used to generate necessary billings and reports.

Managed Care Montana continues to calculate averted costs in the same manner. Following investigation by BCBS, they feel that their method is within current industry standards of averted cost calculations.

6. **Fee Billing**

Wolcott: We recommend the Department prepare the monthly fee billings rather than reviewing and correcting the bill prepared by BCBS.

State: We agree that this is possible and something to consider.

Resolution: This new billing procedure has been implemented by the Department of Administration. The Department now calculates the number of eligible participants and forwards this information with a check for the appropriate administrative costs directly to BCBS on a monthly basis. This information is then used by BCBS to generate a monthly billing which includes an indication of the payment made. As previously noted in the administrative review of this report, BCBS does not check this figure against the number of actual participants showing as covered on their system.

7. **Mental Illness Diagnosis**

Wolcott: We recommend the Department obtain assistance to review the scope of mental illness covered by the Plan.

State: The mental illness benefit was rewritten in the 1991 amendment to the State Plan to define and limit the mental/nervous benefit. Several additional initiatives were taken with assistance of BCBS.

Resolution: In April of 1993 correction of the BCBS claims system coding was made to apply appropriate denials for the State of Montana Employee Benefit Plan. This correction was for wording already in effect under the Plan. In addition a review of this area of benefit determination was completed by BCBS in February, 1994. This review determined which codes within the mental illness diagnosis range were currently being denied under regular BCBS business, but allowed according to the document for the State's Plan. The differences noted have been incorporated into the Plan changes effective September 1, 1994.

8. **Outstanding Claim Drafts**

Wolcott: We recommend the Department research the State's abandoned property law as it relates to the Plan. If the law does not apply, we recommend that outstanding benefit checks be returned to the Plan once they have been outstanding for 12 months.

State: We concur. The matter has been reviewed in the past and will now be revisited from the perspective of a self-insured plan.

Resolution: Legal council for the State of Montana has again reviewed this issue and has determined that stale-dated claim drafts are in fact abandoned property and must be handled appropriately.

9. **Coordination of Benefits**

Wolcott: We recommend the Plan document language be amended to clearly define "allowed expenses" in Chapter 6 so as to provide documentation of the treatment of private room charges for coordination of benefit purposes.

State: We concur. The Coordination with Other Benefit Plans section was revised in the 1992 Plan booklet.

Resolution: The Plan has now been amended to clarify issues of "allowed expenses" as it applies to all benefits in regards to coordination of benefits provisions.

10. **Workers' Compensation**

Wolcott: We once again request that BCBS contact the Workers' Compensation Board to request assistance in determining the existence of claims filed both with the Plan and under Workers' Compensation. We recommend that the Department join in the request.

State: We concur and will join in BCBS's request.

Resolution: Following much contact between BCBS, the Department, legal council for the State of Montana, and the Workers' Compensation Board it was found that a direct information transfer from Workers' Compensation to BCBS, while perhaps the most desirable option, was in fact cost prohibitive at this time.

Segal: We feel that the problem of payment of potential Workers' Compensation claims is still a valid issue. We recommend that in lieu of this direct information transfer, a manual system be set up whereby the State gathers information regarding on-the-job injuries at the time of the initial filing of the injury report, and provide a monthly report to BCBS. The information captured should include the employee's name, social security number, date of injury, type of injury, and accident details as available. Upon receipt of the State's report, BCBS can place appropriate notations in their claims system for automatic identification of potential work related claims that require additional investigation and/or denial.

Following discussions at both the Department of Administration and BCBS, we were advised that both parties would in fact be capable of performing the functions indicated. We recommend that the State pursue this manual approach of providing BCBS with known Workers' Compensation information. By providing as much information as possible to the administrator, they in return, are able to adjudicate claims in a more accurate and efficient manner.

11. **Outpatient Surgery**

Wolcott: We recommend the Plan limit charges for an observation room and normal nursing services following out-patient surgery to the hospital's semi-private room charge. If implemented, this recommendation should assure that out-patient surgery is a cost effective alternative to in-patient care.

State: This was not addressed in the Department of Administration's November 9, 1992 response.

Resolution: Effective March 1,1992, the Plan wording was changed to reflect "The hourly charge for the observation rooms, in total, may not exceed the rate for a semi-private room." In addition to this wording change there has been much internal documentation relating specifically to the coverage available in these types of situations. The system will currently edit and suspend for review any claim that has observation room charges greater than that particular provider's semi-private room charge.

Precertification

Wolcott & Associates' prior audit report also raised concern that the mandatory pre-admission notification process was not used to identify unnecessary hospitalizations. Pre-certification as a cost containment measure was implemented effective September 1, 1992.

SECTION VI

SUMMARY AND RECOMMENDATIONS

Our review of general administrative procedures indicates that Blue Cross Blue Shield of Montana (BCBS) has the proper claim control measures in place for processing benefits available to employees, retirees and dependents of the State Employee Benefit Plan. Although we believe these measures to be adequate, the results of our audit of individual claims payments fell below our expectations. Accordingly, we recommend that BCBS review their established procedures for compliance and make any adjustments necessary to obtain a higher level of claims accuracy.

Statistical Adjustment to Audit Findings

Because the error rate identified through our review exceeded the assumed error rate of 5.7% or less, the predetermined confidence interval (+/-5%) required adjustment. Our actuarial staff has reviewed the audit findings and has made a statistical adjustment to those numbers in order to provide an estimate of the true accuracy rate for all claims processed during each of three audit periods. Our Senior Health Actuary provides the following analysis:

Category of Error	March 1, 1992 - September 30, 1992	October 1, 1992 - December 31, 1992	January 1, 1993 - February 28, 1994
Claims Without Error			
Best Estimate	99.7%	92.4%	99.6%
90% Confidence	97.3-100.0%	86.8-96.2%	97.1-100%
Financial Accuracy			
Best Estimate	99.7%	98.7%	98.9%
90% Confidence	99.5-100.0%	97.6-99.8%	97.5-100.0%

Errors identified in this review can be easily rectified by a review of the findings of this audit with error resolution technicians and placing more emphasis on attaining individual satisfactory accuracy levels through established BCBS internal audit programs.

Turnaround Time

The insurance industry has established 10 to 14 business days as an acceptable standard for prompt handling of claims. Turnaround time is calculated from the date all documentation required for benefit consideration was received to the date the claim was processed for payment or denial. This analysis includes routine delays due to internal review for medical necessity, audit, etc. and excludes delays realized in the issuance of drafts on a scheduled basis.

Based on our review, claims processed during the period of March 1, 1992 through September 30, 1992 achieved these goals. Turnaround time for claims processed in the latter periods reflects averages of 18.6 and 17.6 business days. BCBS has taken measures to reduce multiple stage reviews of system edits. We expect that a more current analysis would indicate that BCBS is processing claims within the acceptable guidelines of 10 to 14 business days.

Recommendations

Comments and recommendations have been provided throughout our report as applicable. These are briefly summarized herein for ready reference.

- Subrogation/Third Party Liability (Page 8)

  BCBS should advise the State of all claims involving third party liability, giving the State option to pursue those claims which the member may choose not to take legal action on.

  BCBS should maintain a log of all on-going and potential subrogation claims. The log should indicate the dollar amount of claims paid out and recoveries received and should be provided to the Department of Administration monthly so the State can adequately track the impact of statute 2-18-902 on the overall recovery of the Plan.

- Reimbursement Allowances (Page 9)

  The impact of reimbursement guidelines relative to nonparticipating providers both in-state and out-of-state should be periodically reviewed to determine the financial impact on employees for utilization of these providers.

- Reports (Pages 11)

  BCBS should continue to provide guidance to the State in understanding current reports and reliability of this data. Detailed updates regarding the new reporting system should be regularly provided to the State.

- Eligibility Discrepancies (Pages 15 and 18)

  BCBS should suspend claims processing on **all** participants who appear on their monthly discrepancy list until such time the State reconciles the report to determined appropriateness of coverage. It is imperative that the State review BCBS's monthly discrepancy lists without delay.

A complete data coverage reconciliation should be conducted at the time the State's new payroll system goes on-line with special emphasis on the self-payment and COBRA participants. Thereafter, verification should be continued on a quarterly basis.

- Premium Billings (Page 19)

  The State and BCBS should review procedures to ensure that the number of participants indicated on the State's billing for administration fees agrees with the number of participants eligible on BCBS files. Appropriate measures should be implemented for the monthly review and resolution of discrepancies.

- Hospital Discount Arrangements (Page 28)

  BCBS is encouraged to revise provider arrangements that allow for reimbursement of otherwise ineligible Plan expenses. The employee should be made wholly responsible for noncovered expenses. For the particular claim in question, the State's reimbursement included $61.20 for a noncovered expense.

- Injections (Page 28)

  Provider charges for injectable drugs are currently paid under the prescription benefit code and subject to the lesser coinsurance level for brand name drugs. We find this process to be inconsistent with industry standards.

- Mental/Nervous ICD9 Codes (Page 28)

  It is imperative that the State provide immediate response to BCBS inquiries. A report was sent to the State in April, 1993 requesting instructions for handling payment errors identified through the review of covered ICD9 diagnosis codes. The State did not respond, therefore, recovery of overpayments was not pursued. The State should review this outstanding matter and instruct BCBS accordingly.

- Prescription Drugs (Page 29)

  Brand name drugs should continue to be processed with a 20% coinsurance differential in order to realize full effect of this cost containment measure. This recommendation requires approval of the State and amendment to the Plan.

  Take home drugs provided upon discharge from a hospital confinement should be isolated from inpatient expenses and paid as prescription expenses subject to the lower coinsurance level (70% brand name versus 75% inpatient).

- Overpayment of Benefit Year Maximum (Page 29)

Claim # 13385518, identified on Worksheet #74, processed March, 1992, exceeded plan limitations. The claims history should be reviewed to determine the amount of the overpayment and a refund requested.

- System Edits (Page 39)

  BCBS should utilize full system capabilities for detection and recoding of fragmented or unbundled expenses.

  BCBS should utilize full system capabilities to track physicians charging multiple 'new' patient exams in order to obtain a greater benefit for established patients.

  BCBS should review the system's data base to determine that multiple surgical procedures are being adjudicated correctly.

  The out-of-state provider threshold of $300 should be expanded to include investigation of those claims which are **not** assigned for provider payment. (Also noted on page 40)

- Workers' Compensation (Page 44)

  Until such time that a cost effective automatic transfer of data is made available to BCBS, the State should provide BCBS with a manual report of all work injuries. BCBS would then place appropriate notations in their claims system for automatic identification of potential work related claims that require additional investigation and/or denial.

* * * * * * * *

This report would be incomplete without recognition of the cooperation and assistance of BCBS staff extended to us during the onsite audit and review process. BCBS staff demonstrated a strong commitment to the constructive approach intended by this audit.

SECTION VII

BCBS RESPONSE

BlueCross BlueShield of Montana

An Independent Licensee of the Blue Cross and Blue Shield Association

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P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Fax: (406) 442-6946

Customer Information Line:
1-800-447-7828

August 30, 1994

MaryAnne L. Watson
The Segal Company
5080 North 40th Street, Suite 400
Phoenix, AZ 85018

RE: Response to Draft Audit Report for the State of Montana Employee Benefit Plan

Dear Ms. Watson:

Following are our comments and responses to the audit for the State of Montana Employee Benefits Plan your firm conducted in early June.

Comments relative to the draft audit report for the State of Montana Employee Benefits audit:

Mail Handling

Helena receives an estimated 1,000 pieces of mail daily or 20,000 pieces monthly, not the estimated 20,000 pieces daily quoted on page 6 of your report.

Draft Distribution

BCBSMT does not have a draft distribution for PPO providers as stated on page 7 of your report.

Usual, Customary, and Reasonable (UCR) Allowances

In the first paragraph on page 10, professional allowances are described as UCR. As of March 1992, a language change was made from "usual, customary, and reasonable allowance" to "prevailing allowance" because the method by which professional reimbursement was made moved off the inflation-driven 90th percentile calculation.

In the second paragraph on page 10, you state; "Out-of-state providers receive reimbursement according to the prevailing allowance applied to participating providers." There is no nonmember differential applied for out-of-state.

Maintenance of Fee Schedules on Provider Files

Paragraph one should read, "The Provider Relations Department works with those providers who are eligible to contract with Blue Cross and Blue Shield of Montana, and, as such, has the authority to have changes made within the participating provider files.

DBM has the only authority to make actual changes on-line." Additions and updates to other provider files, as well as general provider maintenance, is limited to database maintenance (DBM).

Injections

On page 28 you state, "PPO physicians have been instructed to bill separately for their administration fees . . . ." BCBSMT does not have PPO physicians. All physicians are asked to submit the administration fee separately. This allows the system to deny the administration fee if there is a corresponding office call, or to pay the lower administration fee if no office call is necessary.

Responses to Recommendations:

The State be advised of all claims involving third-party liability.

This recommendation gives the State the option of pursuit on claims without indication of legal action. This is possible; however, a more efficient and cost-effective method is to forward a copy of the original notification with which the determination is made. If the State desires to investigate further, a list of claims related to the case can be forwarded. This would be on a case notification basis rather than an individual claim notification basis.

A log be maintained by BCBSMT of all on-going and potential subrogation claims, and this log be made available to the Department on a monthly basis for tracking purposes.

As of June 1, 1994, a manual tracking log is being maintained in the Recovery Unit. This consists of any known open cases, potential cases, and known closed cases. Cases by group can be identified manually at this time. Future plans include a breakdown by group. Also, a system-generated spreadsheet has been requested for faster and more concise reports by case as needed. The long-range goal is to review cases and follow up on a monthly basis.

The Department be made aware of the extent of impact of current UCR guidelines relative to non-participating providers both in- and out-of-state.

BCBSMT concurs with this recommendation.

BCBSMT continue to provide all possible guidance to the State in the understanding of these reports, provide information which is reliable as possible, and continue to provide updates to the Department regarding the progress on the new reporting system.

BCBSMT concurs with this recommendation.

BCBSMT suspend claim processing on all participants who appear on the member eligibility discrepancy listing until such time as the State reconciles the report to determine appropriateness of coverage.

BCBSMT will suspend claim processing on all participants who appear on this listing if it is the desire of the State to do so.

BCBSMT revise its agreement with Rivendell Hospital making the employee wholly responsible for noncovered expenses and providing a discount based on the State's allowable expense.

This agreement allows BCBSMT to obtain a discount of the billed charges without exclusion of non-covered charges. Any lines which are considered noncovered by the benefit Plan are denied. The subscriber (employee) is responsible only for the discounted billed charge of the denied service. We believe this is a benefit to the subscriber and does not adversely affect the Plan in any way.

Other Payment Error -- A file involving a mental/nervous condition be reviewed and the appropriate overpayment requested.

BCBSMT will review and request overpayment.

Recommendations pages 38 and 39.

1. **BCBS should utilize full system capabilities for detection and recording of fragmented or unbundled expenses.**

   BCBSMT reviewed rebundling software products approximately two years ago. Due to the emphasis on the conversion to LRSP, it was decided to postpone this effort until the new system was operational. BCBSMT plans to reactivate this goal in 1995.

2. **BCBS should utilize full system capabilities to track physicians charging multiple 'new' patient exams for established patients in order to obtain a greater benefit.**

   Rebundling software will track this situation and flag for investigation or correction. BCBS will also pursue any internal methods of identifying these claim situations, i.e., PLASM coding and procedural investigation.

3. **BCBS should review the system's database to determine that multiple surgical procedures are being adjudicated correctly.**

   Rebundling software may be able to track this situation. BCBS will also consider either an intensive review of the database, including any necessary recoding, or check into a retrospective review report based on volume and/or complexity.

4. **The out-of-state provider investigation threshold of $300.00 should be expanded to include investigation of those claims which are not assigned for provider payment.**

   This edit has been in place since May, 1993. All original entry claims pass through this edit and suspend as recommended by Wolcott and Associates, Inc. The test situation developed and used during the Segal Audit happened to have used a reprocessed claim. Reprocessed claims do not pass through this edit. BCBS will look into revising this edit to pick up these transaction types when appropriate; i.e., provider ID has been modified.

This concludes our response to your draft audit report. I thank you and your staff for the professionalism and courtesy displayed during this audit. It was our pleasure to work with you.

Sincerely,

Keith Wolcott, Director
Internal Audit

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SECTION VIII

STATE ADMINISTRATION RESPONSE

DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL DIVISION

MARC RACICOT, GOVERNOR

MITCHELL BUILDING, ROOM 130
PO BOX 200127

STATE OF MONTANA

(406) 444-3871
FAX: (406) 444-0544

HELENA, MONANA 59620-0127

September 2, 1994

Mary Anne L. Watson
The Segal Co.
5080 North 40th Street, Suite 400
Phoenix, AZ 85018

Dear Ms. Watson:

I have received your audit report on administration of the State Employee Benefit Plan and provide the following response to your recommendations.

I. Subrogation/Third Party Liability

RECOMMENDATION:

BCBS should advise the State of all claims involving third party liability, giving the State the option to pursue those claims in which the member may choose not to take legal action.

RESPONSE:

Implementing this recommendation makes sense if it is the State's intention to follow up on cases referred by BCBS. The statutory restriction on subrogation rights—limiting recovery to amounts in excess of "full compensation"— has caused some previous State attorneys to conclude that pursuit of recovery is only cost effective if it is limited to ideal cases. Cases in which, the injured party has chosen not to take legal action — generally because liability is unclear or because the liable party has no insurance or attachable assets — are typically not good prospects.

Not withstanding these reservations, due to some recent recovery successes, we agree to implementing this recommendation for a trial period of six months to assess the merits of expanding recovery efforts.

RECOMMENDATION:

BCBS should maintain a log of all on-going and potential subrogation claims. The log should indicate the dollar amount of claims paid out and recoveries received, and these should be provided to the Department of Administration monthly so the State can adequately track the impact of statute 2-18-902 on the overall recovery of the Plan.

RESPONSE:

We concur with this recommendation and will provide BCBS with information on case disposition and any recoveries.

II. Usual, Customary and Reasonable (UCR) Allowances

RECOMMENDATION:

The impact of UCR guidelines relative to nonparticipating providers, both in-state and out-of-state, should be periodically reviewed to determine the financial impact on employees for utilization of these providers.

RESPONSE:

We concur with this recommendation. The area of greatest concern is the financial impact on employees, who must use out-of-state providers either because they are located out-of-state when the service is needed or because the service is not available in Montana. These employees do not have the option of using participating Montana providers who accept allowances.

We understand that BCBS is negotiating with other BCBS Plans for reciprocity on provider agreements which would make member providers who accept allowances available across the country. We anticipate making this program available to our members as soon as possible. It will allow members who need

out-of-state medical services to protect themselves against out-of-pocket costs and help control plan costs. In the mean time, we will review with BCBS their procedures for setting out-of-state allowances to assure they meet plan objectives.

III. Reports

RECOMMENDATION:

BCBS should continue to provide guidance to the State in understanding the reliability of data in current reports and provide detailed updates regarding the new reporting system.

RESPONSE:

We concur with this recommendation. The absence of reliable reports precludes adequate program evaluation and needs to be remedied as soon as possible.

IV. Eligibility Discrepancies

RECOMMENDATION:

BCBS should suspend claims processing on all participants who appear on their monthly discrepancy list until such time as the State reconciles the report or determines appropriate coverage. It is imperative that the State review BCBS's monthly discrepancy lists without delay.

RESPONSE:

A new on-line eligibility computer system, which has been under development over the past three years, is currently going into production. This system internally reconciles premium payment, coverage periods and coverage type. BCBS will process claims exclusively off a system-generated certification tape and updates so there will be no discrepancies.

Most, but not all, of the discrepancies under the old system were timing discrepancies. Changes in premiums collected to reflect coverage changes were

implemented by agency payroll personnel. These premium changes automatically triggered a change in coverage codes sent to BCBS on the monthly certification tape. BCBS ran each months' certification tape against the previous month's tape to identify adds, changes and deletes.

Standard procedure was to hold off implementation of adds (new enrollees) and changes until employee-signed enrollment and change-of-status forms were received by BCBS. Since these were first sent by over 70 payroll clerks across the state to the Employee Benefits office and then to BCBS, many arrived after the certification tape. Any adds or changes without hard copy were placed on the discrepancy list; when hard copy was received, the change was made retroactively to the specified effective date.

Implementation of deletes identified from the certification tape went into effect immediately. There is no employee-signed hard-copy termination form since terminations are triggered by events rather than employee elections—termination of employment or failure of self-pay employees or retirees to make premium payments.

The termination reviewed by the audit (#4) did not reflect standard procedure. It was not processed off the tape, but put on the discrepancy list, apparently because BCBS had some reason to question the termination. If placing terminations on the discrepancy list and continuing to pay claims until the discrepancy is resolved were standard procedure, we would agree that claims should have been suspended, and that faster resolution would have been critical.

RECOMMENDATION:

A complete data coverage reconciliation should be conducted at the time the State's new benefits computer system goes into effect with special emphasis on self-pays; verification should be continued on a quarterly basis.

RESPONSE:

We concur; a complete reconciliation is currently in progress and verification checks will be conducted at least quarterly during the first year to assess system operation.

V. Premium Billings

RECOMMENDATION:

The State and BCBS should review procedures to ensure that the number of participants indicated on the State's billing of administration fees agrees with the number of participants in BCBS files.

RESPONSE:

We have no problem with this recommendation if BCBS feels it is necessary or desirable to assure the state is complying with contract terms.

VI. Hospital discount arrangements

RECOMMENDATION:

BCBS is encouraged to revise provider agreements that allow for reimbursement of otherwise ineligible Plan expanses.

RESPONSE:

We concur with BCBS's response.

VII. Injections

RECOMMENDATION:

Provider charges for injectable drugs are currently paid under the prescription benefit code and subject to the lesser coinsurance level for brand name drugs. We find this process to be inconsistent with industry standards.

RESPONSE:

In their response to the audit findings, BCBS indicated that they ask physicians to submit the administration fee separately from the prescription fee to allow

the system to deny the administration fee if there is a corresponding office call charge.

While that appears appropriate, effective September 1, 1994, BCBS will no longer be able to process the prescription fee under prescription drug benefits. Prescription drug benefits have been carved out into a separate plan, administered by another organization. We will work with BCBS to determine how the remaining prescription fee will be processed.

VIII. Mental/Nervous ICD9 Codes

RECOMMENDATION:

It is imperative that the State provide immediate response to BCBS inquiries. A report was sent to the State in April, 1993, requesting instructions for handling payment errors identified through review of covered ICD9 diagnosis codes. The State did not respond, therefore, recovery of overpayments was not pursued. The State should review this outstanding matter and instruct BCBS accordingly.

RESPONSE:

We concur with this recommendation. We have no record of receiving this report in April of 1993. Since the audit, we have obtained a copy and instructed BCBS on recovery.

IX. Prescription Drugs

RECOMMENDATION:

Brand name drugs should continue to be processed with a 20% coinsurance differential (after stop loss) in order to realize the full effect of this cost containment measurer.

RESPONSE:

We agree with this in principle, however, BCBS has not had the systems capability of applying the differential only where the member has a choice—

where there is a generic equivalent on the market. Continuing the differential indefinitely under this circumstance would be unnecessarily punitive. Under the new prescription plan, maximizing generic substitution is a responsibility of the prescription drug program manager, and it is unclear whether an extended differential will be needed.

RECOMMENDATION:

Take home drugs provided upon discharge from a hospital confinement should be isolated from inpatient expenses and paid as prescription expenses subject to the lower coinsurance level (70% brand versus 75% inpatient).

RESPONSE:

While we have no problem with this in theory, prescription benefits have been carved out of the medical plans into a separate plan. There will be no medical plan prescription benefit for BCBS to pay this under in the future, unless a special one is created. We will explore this further with BCBS.

X. Overpayment of Benefit Year Maximum

RECOMMENDATION:

BCBS should review an overpayment identified in the audit and determine a refund.

RESPONSE:

We concur with this recommendation.

XI System Edits—Four recommendations

RESPONSE:

We concur with all four recommendations, and we are pleased that BCBS indicated in their response that they are pursuing them.

XII Workers' Compensation

RECOMMENDATION:

Until such time that a cost effective automatic transfer of data is made available to BCBS, the State should provide BCBS with a manual report of all work injuries. BCBS would then place appropriate notations in their claims system for automatic identification of potential work related claims that require additional investigation and or denial.

RESPONSE:

We concur with this recommendation.

We appreciate the thoroughness of your audit report, and the opportunity to respond.

Sincerely,

Joyce Brown
Chief, Employee Benefits

JB/mmb